COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF INDUSTRIAL ACCIDENTS **BOARD NO. 008072-90**

Stephen Cicerano	Employee
Home Parenteral Care, Inc.	Third Party Claimant
Torello Painting Co.	Employer
Preferred Mutual Insurance Co.	Insurer

REVIEWING BOARD DECISION

(Judges Costigan, Maze-Rothstein and Levine[1])

APPEARANCES

William H. Troupe, Esq., for the third party claimant
Michael E. Scott, Esq., for the insurer at hearing
Joanne T. Gray, Esq., Christopher P. Cifra, Esq., and Brian T. Dougan, Esq., for the insurer on appeal

COSTIGAN, J. Of the several issues raised by the insurer on appeal from a judge's decision awarding medical benefits under G. L. c. 152, §§ 13 and 30, we consider only one as having merit: whether the administrative judge committed error of law by ordering payment to the third party medical provider, Home Parenteral Care, Inc., in excess of rates of reimbursement established by the Massachusetts Division of Health Care Finance and Policy, under the provisions of c. 118G.[2] We agree with the insurer that the decision, as to this issue, may be contrary to law, and therefore recommit the case for further findings. We summarily affirm the decision as to all other issues argued by the insurer.

---

[1] Judge Levine did not participate in deciding this appeal, as he was the administrative judge at an earlier proceeding in this case.

[2] The insurer frames this issue as whether the judge erred in ordering payment above and beyond the rate set by the Massachusetts Rate Setting Commission under the provisions of G. L. c. 6A, § 32(4), as provided in § 13 of c. 152. (Insurer brief, 6, 7-10.) However, the medical services at issue here were provided from December 2000 through March 2002, well after the 1996 amendment to § 13(1) which substituted "division of health care finance and policy under the provisions of chapter one hundred and eighteen G," for "rate setting commission under the provisions of chapter six A." St. 1996, c. 204, § 36.

The employee was rendered a quadriplegic by injuries sustained in a January 30, 1990 industrial accident. The insurer paid him § 34 temporary total incapacity benefits for the 260-week statutory maximum applicable to his date of injury, and then § 34A permanent and total incapacity benefits, until he settled his accepted claim by a § 48 lump sum agreement in April 1995. In 1997 he relocated to Oregon, where Home Parenteral Care, Inc. (HPC) provided medical services to the employee commencing in March 1997. (Dec. 840.) The insurer approved the employee's treatment regimen of intravenous antibiotic therapy at various times throughout the period 1997 through 2000, and promptly paid all bills that the provider submitted for such treatment. (Dec. 841.)

In March 2000, HPC began to supply the employee with morphine for his severe pain. At that time, the employee was in a hospice, and that facility paid HPC for the morphine. The employee was discharged from the hospice in June 2000, and continued to receive morphine at home. HPC began billing the workers' compensation insurer, which orally agreed to pay one hundred per cent of the cost of the morphine and related services. The employee's treating physicians had prescribed the morphine in anticipation of his imminent death. However, the employee survived, and by March 2002, he had been weaned off that narcotic pain killer. (Dec. 841.)

The insurer paid for the employee's morphine treatments until November 2000. In December 2000, the insurer informed HPC that the morphine treatments were under utilization review. In May 2001, having not been paid for six months, HPC filed a claim for payment of the morphine treatments.[3] (Id.) Following a § 10A conference, on October 11, 2001 the administrative judge ordered the insurer to pay the morphine treatment bills that HPC presented at the proceeding. The insurer appealed to a full evidentiary hearing, (Dec. 838), and eventually paid some of the bills that were presented

[3] The third party claimant complains that it did not receive a written denial or other answer to its claim from the insurer until February or March 2002. (Third Party Claimant brief, 2, 3, 6.) Although it would be better practice for insurers to respond in writing to all claims, the statute requires that they do so only as to "an *initial* written claim for *weekly benefits* on a form prescribed by the department," and only if that claim is received before the employer's first report of injury." G. L. c. 152, § 7(1). (Emphasis added.)

at the conference.[4] Even before the case came on for hearing on the insurer's appeal, HPC wrote to the judge to lodge its objection to the insurer's handling of his conference order.[5]

The hearing de novo took place on June 26, 2002, with witnesses for HPC testifying in person before the judge, and the employee testifying by deposition from Oregon. (Dec. 837.) In defense of the third party claim, the insurer challenged the reasonableness and necessity of the provision of morphine and related services, for which payment of charges totalling $193,781.17 was claimed. (Dec. 836.) In his decision filed on May 28, 2003, the judge found that the morphine treatments were reasonable and necessary, and that the insurer must pay HPC's bills. (Dec. 843.) He ordered that the insurer pay the claimant $115,819.18 which, he explained, was the amount the claimant, in its brief to him, said it was owed as of December 2, 2002, after applying the payments already made by the insurer. (Dec. 843-844.)

---

[4] The record is woefully inadequate as to the amount claimed by HPC and the amount paid by the insurer. The administrative judge stated that the bills presented at conference totalled approximately $200,000, and that his order had directed payment of the requested medical bills. (Dec. 838.) The third party claimant asserts that the insurer made no payment pursuant to the conference order until January 22, 2002 when, without explanation, it paid outstanding bills only through March 27, 2001, and only in the amount of $115,819.18. (Third Party Claimant brief, 3.) The insurer agrees that it "paid the outstanding invoices through March 2001 at Department of Industrial Accidents rates totally [sic] one hundred fifteen thousand dollars ($115,000)." (Insurer brief, 2.) The third party claim at hearing was stated to be for payment of $193,781.17 in medical bills. (Dec. 836, 837.) Given the de novo nature of the hearing, it was proper for both the third party claimant and the judge to identify the total charges billed as the amount of the claim, without regard to what payment the insurer made pursuant to the conference order, except by way of allowing the insurer a credit for such payment against the award in the hearing decision. However, absent a finding that the total charges comported with the rates established by the Division of Health Care Finance and Policy, as required by § 13, it was error for the judge to order the insurer to pay the total charges billed by HPC.

[5] We take judicial notice of a January 30, 2002 letter, contained in the board file, from counsel for the third party claimant to the administrative judge, alerting the judge to the insurer's late and incomplete payment of his conference order. See Rizzo v. M.B.T.A., 16 Mass. Workers' Comp. Rep. 160, 161 n.3 (2002). Without conceding that "Rate Setting Commission" rates applied to his client's claim, counsel for HPC objected to the insurer's apparent use of such rates, as well as its payment of a much shorter period of charges than covered by the conference order.

However, the next day -- without explanation -- the judge corrected his decision by directing the insurer to pay HPC the amount of $194,143.77, which was significantly higher than the amount ordered in the original decision, and even slightly higher than the amount identified twice in the decision, (Dec. 836, 837), as claimed by HPC.[6] (May 29, 2003 letter of administrative judge to counsel, contained in the board file.) See Rizzo, supra.

Neither party offered evidence as to what the applicable Massachusetts rates were for the morphine treatments, or even if such rates exist.[7] The arguments made on appeal suggest that the judge's corrected award did, in fact, require the insurer to pay in excess of applicable Massachusetts rates, but on this record, we are unable to so conclude.

---

[6] In his brief on behalf of the third party claimant, counsel for HPC explains that the amount of $194,143.77, the total balance shown on the bill entered into evidence, (Ex. 10), includes $367.60 in legal costs associated with the employee's deposition in Oregon. He stipulates that those costs were not properly part of the third party claim decided by the judge. (Third Party Claimant brief, 7.)

[7] Section 2(b) of G. L. c. 118G, as appearing in St. 1997, c. 43, § 97, provides that one of the duties of the Division of Health Care Finance and Policy is,

> to establish certain rates of payment for health care services. *The division shall have the sole responsibility* for establishing rates to be paid providers of health care services by governmental units, including the division of industrial accidents, which are reasonable and adequate to meet the costs which are incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal law, regulations and quality and safety standards, and which are within the financial capability of the commonwealth.

(Emphasis added.) Even if the Division of Health Care Finance and Policy has not established rates for the morphine treatments at issue, the administrative judge is without authority to correct that omission. Compare Stevens v. Northeastern Univ., 11 Mass. Workers' Comp. Rep. 167 (1997)(under G. L. c. 152, § 30, paragraph 4, administrative judge may order insurer to pay for fitting employee with artificial eye or limb, or other mechanical appliance, such as specially equipped van, if judge finds such fitting will promote employee's restoration to or continuance in industry); Armstrong v. Carlyle Constr., 16 Mass. Workers' Comp. Rep. 467 (2002) (administrative judge may limit award of "expenses necessary incidental to" health care services under § 30, paragraph 1, to cost of converting van to wheelchair accessible).

We agree with the insurer that under the express provisions of § 13,[8] the administrative judge lacked authority to order payment of the subject bills at any rates other than those established by the Massachusetts Division of Health Care Finance and Policy, under the provisions of c. 118G, for the services rendered. See Tedeschi v. S & F Concrete, 6 Mass. Workers' Comp. Rep. 120 (1992)(medical services rendered by out-of-state providers are subject to rates established by Massachusetts Rate Setting Commission).[9] We disagree, however, with HPC's argument, which the judge apparently found persuasive, (Dec. 843), that the insurer was estopped from disputing the rate of reimbursement in the present claim because a) it did not explicitly identify that dispute in its issues statement, (Ex. 2), and b) it orally agreed to pay one hundred per cent of the charges for the morphine treatments, and did so for over six months[10]

---

[8] G. L. c. 152, § 13, as amended by St. 1996, c. 204, § 36, provides in pertinent part:

> (1) The rate of payment by insurers for health care services adjudged compensable under this chapter shall be established by the division of health care finance and policy under the provisions of chapter one hundred and eighteen G; provided, however, that a different rate of services may be agreed upon by the insurer, the employer and the health care service provider.
>
> Except as provided above, no insurer shall be liable for hospitalization expenses adjudged compensable under this chapter at a rate in excess of the rate set by said division, or for other health services in excess of the rate established for that service by the said division, regardless of the setting in which the service is administered . . . .

[9] But see Borgosano v. Babcock & Wilcox Power Co., 10 Mass. Workers' Comp. Rep. 120 (1996)(under Supremacy Clause, federal rates payable for medical services provided by Veterans' Administration).

[10] "Here, clearly, months and months of payments in full certainly indicate an acquiescence to the existence that [sic] there was a contract and agreement that would result in the insurer paying thousands of dollars in medical bills prior to the claim sub judice." (Third Party Claimant brief, 8.) This is akin to arguing that because an insurer agrees to pay § 34 total incapacity benefits prospectively, i.e., "to date and continuing," it is estopped from later disputing the extent of incapacity, at least for the statutory maximum period of entitlement. The fallacy of both arguments is evident.

Generally, "[o]bjections, issues or claims – however meritorious – that have not been raised" below, are waived on appeal. Green v. Town of Brookline, 53 Mass. App. Ct. 120, 128 (2001), quoting Wynn & Wynn, P.C. v. Massachusetts Comm'n Against Discrimination, 431 Mass. 655, 674 (2000). "This rule applies to arguments that could have been raised, but were not raised, before an administrative agency." Green, supra. Here, however, the argument concerning the applicable rate of reimbursement could not have been raised below, because the insurer was not obliged at hearing to assert a defense against a legal impossibility -- the judge ordering payment in violation of § 13 of c. 152. The error of law which the insurer alleges was not born until the judge filed his hearing decision. Thus, contrary to HPC's argument, that issue is properly before us.

The third party claimant correctly argues that pursuant to § 13(1), the insurer, the employer and the health care service provider *may agree* upon a different rate than that established by the Division of Health Care Finance and Policy. (See footnote 8, supra.) Section 19, however, requires that, "[e]xcept as otherwise provided by section seven, any payment of compensation shall be by written agreement by the parties and subject to the approval of the department." Medical benefits are part of the compensation provided by c. 152. Boardman's Case, 365 Mass. 185, 192-193 (1974). The third party claimant does not contend that it had any such written agreement with the insurer. Moreover, even if there were such an agreement, it would not bar the insurer from disputing, for example, the continuing reasonableness and necessity of future medical services, or the causal relationship of such medical services to the work injury. See Lee v. Lynn Plastics Corp., 13 Mass. Workers' Comp. Rep. 105 (1999)(hearing decision's generic award of payment for "reasonable and adequate medical treatment" did not preclude insurer from disputing causal relationship of subsequent medical services to the work-related injury). This is because "[m]edical conditions are dynamic and changing. It is often impossible to ascertain future circumstances with precision." Marchand v. Waste Mgmt. of Mass, Inc., 14 Mass. Workers' Comp. Rep. 332, 335 (2000).

For these reasons, on the facts of this case, we reject HPC's contention that the oral agreement at issue constituted a contract that bound the insurer indefinitely.

> "Since the parties were subject to the [workers'] compensation act, 'all their rights arising under it are to be settled by the agencies there provided and not as actions at common law.' Young v. Duncan, 218 Mass. 346, 351 [1914]."

Bertocchi's Case, 58 Mass. App. Ct. 561, 565 (2003), quoting Conlon v. Lawrence, 299 Mass. 528, 532 (1938).[11] The insurer was entitled to dispute that the ongoing morphine treatments remained reasonable and necessary. Once it did so, compelling HPC to file a claim for payment of its bills, the judge was bound by the rates established by the Division of Health Care Finance and Policy. He could not properly resurrect, and hold the insurer to, its original oral agreement to pay one hundred per cent of charges submitted.

Accordingly, because the judge made no findings as to the applicable rates of reimbursement for the health care services provided by HPC, if any, we reverse the hearing decision's order of payment, and recommit the case for further findings on this issue. See Crowell v. New Penn Motor Express, 7 Mass. Workers' Comp. Rep. 3, 4-5 (1993)(where there is no way to discern the reasoning behind the judge's award of benefits, recommittal is appropriate); G. L. c. 152, § 11C.

On recommittal, the judge must make findings on the correct amount due under G. L. c. 152, § 13, pursuant to such applicable Massachusetts rates as may exist, and he must then direct the insurer to pay HPC such amount, allowing credit to the insurer for the amount it paid pursuant to the 2001 conference order.

So ordered.

_____
Patricia A. Costigan
Administrative Law Judge

_____
Susan Maze-Rothstein
Administrative Law Judge

Filed: **June 25, 2004**

[11] In Bertocchi, the insurer's oral offer of a lump sum settlement, orally accepted by the employee, was held not cognizable under c. 152, in the absence of a written lump sum settlement agreement entered into by the parties before the employee's death, and subject to the approval of the department, as required by § 19 of c. 152.